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EMBRACING JUSTICE ROBERTS' "NEW MEDICAID"

SIDNEY D. WATSON*

Sandra Pico earns \$15,000 a year, too much to qualify for Medicaid in Florida. Mrs. Pico works as a home health aide, supporting her 15-year-old daughter and her husband Manuel who can no longer find work as a carpenter. Their daughter is covered by Medicaid, but Mr. and Mrs. Pico make too much to qualify.¹

In Texas, Mathew Solis also cannot qualify for Medicaid. Mr. Solis, 22 years old, works 25 hours a week earning minimum wage at a building supply store and goes to college full time. His annual wages of \$8,700 a year put him over the income limits for Texas Medicaid.²

I. INTRODUCTION

Sandra Pico and Mathew Solis are among the millions of working adults earning near or below the federal poverty level (FPL) who are excluded from state Medicaid programs. Some, like Sandra Pico, earn too much money. Others, like Mathew Solis, do not fit within Medicaid's categories of eligibility that have traditionally limited coverage to adults who are parents with dependent children, the severely disabled, and the elderly.³ Still others have savings or assets that disqualify them. Many are simply discouraged from applying because the process is complicated, burdensome, and intrusive. All in all, Medicaid covers only about 21% of low-income working age adults.⁴ It is a safety net full of holes.

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1. Carla K. Johnson & Kelli Kennedy, *Medicaid Expansion Rejected by Governors Who Say Earning \$11,000 is Too Much*, HUFFINGTON POST (Aug. 14, 2012), http://www.huffingtonpost.com/2012/08/14/medicaid-expansion-gop-governors_n_1775973.html?ncid=txtlnkushpimg000000037.

2. *Id.*

3. See *infra* text accompanying notes 21-22.

4. KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: A PRIMER 3 (Jun. 2010), available at <http://www.kff.org/medicaid/upload/7334-04.pdf>.

The Affordable Care Act (ACA) changes Medicaid. It expands coverage and makes it the foundation block of a multi-layered social insurance system that provides health insurance for *all* Americans and certain legal immigrants. The ACA expands Medicaid to cover all children and non-elderly adults with incomes up to 133% of the federal poverty level, \$15,414 for a single person and \$26,344 for a family of three.⁵ It offers Medicaid to Sandra Pico and her husband, Mathew Solis, and millions of other low-wage workers. New federal income tax credits will subsidize sliding scale premiums for those earning higher amounts up to 400% federal poverty level, or \$76,360 for a family of three.⁶ Those who have affordable employer-sponsored insurance keep it, but effective 2014 those without employer-sponsored insurance will have these new options.

However, in *National Federation of Independent Business v. Sebelius* (NFIB) the Supreme Court held that states do not have to expand their Medicaid programs to include all working age adults with incomes up to 133% of the poverty level.⁷ In a move that shocked pundits, Supreme Court bloggers, and just about everyone, Chief Justice Roberts, writing for a seven justice majority, concluded that Congress could not constitutionally compel states to expand their Medicaid programs to cover all low-income adults.⁸ However, in an equally surprising second move, Justice Roberts, writing for a different five-member majority of the Court, also allowed the ACA Medicaid Expansion to stand by severing the Expansion from the enforcement provision that threatened states with the loss of all Medicaid funding as the penalty for failing to implement the Expansion.⁹ Thus, the ACA's Medicaid Expansion for adults remains part of the ACA and the Medicaid statute, but the Expansion is now a voluntary choice for states.

Justice Roberts' decision that states cannot constitutionally be compelled to implement the Medicaid expansion for adults relies, in part, on his conclusion that the Medicaid Expansion creates a "New" Medicaid program, not merely an extension of the "Old" Medicaid that existed before

5. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. 1396a (2011)) [hereinafter ACA]; *Who Benefits from the ACA Medicaid Expansion?*, KAISER COMM'N ON MEDICAID & THE UNINSURED (Jun. 2012), http://www.kff.org/medicaid/quicktake_aca_medicaid.cfm.

6. ACA §1401 (codified at I.R.C. § 36 (2011)); KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 5.

7. See *Nat'l Fed'n of Indep. Bus.*, 132 S.Ct. 2566, 2606-07 (2012) [hereinafter NFIB].

8. See *id.* at 2603-04 (2012). Chief Justice Roberts, joined by Justices Breyer and Kagan and supported by a joint dissent from Justices Scalia, Kennedy, Thomas and Alito, held that the ACA Medicaid Expansion crossed the Spending Clause's constitutional line where "the financial inducement offered by Congress is so coercive that 'pressure turns into compulsion.'" *Id.* at 2604.

9. *Id.* at 2607.

the ACA's enactment.¹⁰ Justice Roberts calls the Expansion "a shift in kind, not merely degree," that "transforms" Medicaid.¹¹

Justice Roberts' characterization of the ACA's Medicaid Expansion for adults is wrong, both as a matter of statutory interpretation and legislative history: Medicaid has always given states the discretion to cover more low-income adults including those who are neither parents nor disabled.¹² The ACA Medicaid Expansion makes it financially easier for states to cover these adults, but it does not reflect a fundamental shift in the program.

However, when one looks beyond the Medicaid Expansion for adults that was the subject of the *NFIB* decision and examines more closely the panoply of changes that the ACA brings to Medicaid, Justice Roberts' talk of a "New Medicaid" rings true. The ACA implements a variety of Medicaid reforms that do "transform" Medicaid. The ACA changes Medicaid from a welfare program with complicated and burdensome rules that make it difficult to qualify for coverage into part of a larger social health insurance system designed to bring affordable health insurance coverage to all Americans. To put Justice Roberts' words in this larger context and outside of the narrow issue litigated in *NFIB*, the totality of the changes that the ACA brings to Medicaid makes it "no longer a program to care for [only] the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage [for all]."¹³

Part II describes "Old Medicaid" — the program prior to passage of the ACA and its associations with the world of welfare. Originally designed primarily, but not exclusively, to cover those who received cash welfare, Medicaid for adults has remained tethered to old cash welfare rules; and thus, is designed to exclude all but the most destitute, particularly those who are working or who can work. These welfare rules have never functioned equitably in the Medicaid context, where they exclude most low-wage workers even though they are typically not offered health insurance.

Part III explains how the ACA transforms Medicaid from a welfare model into part of a new social health insurance system. The ACA changes Medicaid from a welfare program with cumbersome, complicated, and stigmatizing rules meant to exclude many into a component of a larger social insurance system that seeks to cover all Americans.¹⁴ In this sense, the

10. *Id.* at 2606.

11. *Id.* at 2605.

12. See Sidney D. Watson, *Old Medicaid, New Medicaid: Where Justice Roberts Went Wrong in National Federation of Independent Business v. Sebelius*, 101 U. KY. LAW J. (forthcoming 2013).

13. *NFIB*, 132 S.Ct. at 2606.

14. Even if Roberts' conclusion that the Patient Protection and Affordable Care Act creates a New Medicaid is correct as a matter of policy, it does not mean that Roberts' legal conclusion on spending clause coercion is correct. For a growing body of literature

ACA does create a New Medicaid that is drastically different from Old Medicaid.

Part IV explains why policy makers and the public will embrace this New Medicaid. It describes whom the ACA Medicaid Expansion for adults will cover and how it offers a social safety net to middle class Americans as well as the nation's neediest and most vulnerable. It cautions policy makers to begin thinking about New Medicaid as a social insurance for all, not just a program for "the poor." Although the Supreme Court's ruling in *NFIB* means that states do not have to adopt the ACA Medicaid Expansion for adults, this new social insurance version of Medicaid offers a new vision of Medicaid that should be politically popular, politically stable, and financially sustainable.

II. OLD MEDICAID

Prior to the passage of the ACA, Medicaid was already the nation's largest health insurance program covering nearly 60 million children, adults, and seniors, 17% of the population.¹⁵ Medicaid is a joint federal-state program that provides federal financial assistance to states operating approved medical-assistance plans.¹⁶ Its federal-state structure makes it an attractive financing option for states but also places constraints on how states structure their Medicaid programs. Federal law outlines broad "mandatory" requirements for eligibility, benefits, and administration that state Medicaid programs must meet, but states retain considerable flexibility to cover additional "optional" categories of eligibility, services and administration.¹⁷ States may also seek "waivers" from the Secretary of Health and Human Services (HHS) to use Medicaid funds to pay for services not otherwise authorized by the federal statute and regulations.¹⁸

questioning the Roberts' spending clause analysis, see Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in the Healthcare Case*, 93 B.U.L. REV. 1 (2013).

15. KAISER FAMILY FOUND., 5 KEY QUESTIONS AND ANSWERS ABOUT MEDICAID 2 fg.2, 3 fg.3 (2012), available at <http://www.kff.org/medicaid/upload/8162-02.pdf>. Medicaid covers 17% of Americans, Medicare covers 12%, various employer sponsored insurance covers 49%, 5% have individual policies, and 16% of Americans are uninsured. *Id.*; see also KAISER FAMILY FOUND., THE MEDICAID PROGRAM AT A GLANCE 1 (2012), available at <http://www.kff.org/medicaid/upload/7235-05.pdf>.

16. See 42 U.S.C. §§ 1396-1396v (2011).

17. See *id.* §§ 1396a, 1396d.

18. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to waive statutory and regulatory provisions of health and welfare programs, like Medicaid. Social Security Act, Pub. L. No. 74-271, § 1115, 49 Stat. 620 (codified as amended at 42 U.S.C. § 1315(a)(1) (2011)). Section 1915(c) of the Act gives the Secretary authority to waive statutory and regulatory provisions to operate homes and community based long-term care programs. *Id.* States can also obtain waivers to expand managed care programs under Section 1915(b) waivers. 42 U.S.C. § 1396n (2011).

Medicaid's joint federal-state structure and the flexibility it gives states to design and administer their own programs has made it an attractive financing option for states. The federal Medicaid contribution is open-ended, limited only by the amount of state funds individual states are willing to contribute. The pre-ACA, traditional federal Medicaid match rate for services ranges from 50% to 73%, depending on the state's per capita income — with poorer states entitled to a higher federal contribution.¹⁹ With an average federal match rate of about 59%, Medicaid allows states to, at a minimum, "double their money" by using Medicaid to finance medical care.²⁰ As a result, Medicaid has grown to the largest of all federal grant-in-aid programs; in 2010, it accounted for 57% of federal revenue coming into states and 22% of total state budget spending.²¹

Medicaid has also been a safety net insurer full of holes, particularly for adults. At the time of passage of the ACA, Medicaid covered only 42% of poor Americans.²² While federal law required states to cover all poor children, federal law made it harder for states to cover low-income, non-elderly adults. As a result, in 2010 Medicaid covered 56% of poor children but only 21% of poor working-age adults.²³

The challenges with using old Medicaid to cover adults come from Medicaid's genesis as a welfare program. While Medicare was created as a social insurance program, available to all the nation's elderly, Medicaid was conceived as a welfare program, available only to those low-income children and adults deemed to be the worthy poor.

When Medicaid was enacted in 1965 it was intended primarily, although not exclusively, as medical assistance for those who received cash welfare or who fit within the old welfare categories of the worthy poor — the elderly, the blind and disabled, and families with dependent children.²⁴ Its

19. 42 U.S.C. § 1396d(b) (2011). The Federal Medical Assistance Percentage (FMAP) is computed from a formula that takes into account the average per capita income for each State relative to the national average. *Id.* The FMAP cannot be less than 50%. See *id.* For fiscal year 2013 match rates, see 76 Fed. Reg. 74061, 74062-63 (Nov. 30, 2011). See also KAISER FAMILY FOUND., *Federal Matching Rate and Multiplier*, STATE HEALTH FACTS, <http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4> (last visited Mar. 3, 2013).

20. See KAISER FAMILY FOUND., AN OVERVIEW OF CHANGES IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGES (FMAP) FOR MEDICAID 2 (July 2011), available at <http://www.kff.org/medicaid/upload/8210.pdf>.

21. *Health Policy Brief: Extra Federal Medicaid Support Ends*, HEALTH AFF., available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=50 (last updated July 14, 2011).

22. KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 5 at 3.

23. *Id.*

24. See ROBERTS STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 61-62 (1974).

rules came from the world of welfare that sought to distinguish between the “worthy poor” who were deserving of public aid and those who were undeserving because they should be working. Welfare rules have always made applying for assistance cumbersome and demeaning to discourage those deemed “non-deserving” and “non-needy” from applying, and to make work seem the more attractive option.²⁵

Medicaid for children and pregnant women shed these welfare rules and state Medicaid programs, even prior to the ACA, were required to cover all poor children and pregnant women.²⁶ However, Medicaid coverage for working age adults remained entangled in old welfare rules that created a variety of problems for states that wanted to expand Medicaid to cover all low-income adults.

First, Medicaid eligibility for adults was still tied to categories of eligibility derived from old welfare programs: States could cover non-elderly adults who were parents, permanently and totally disabled, or pregnant women — the old categories of the worthy poor in cash welfare programs — but there was no category of eligibility for other adults under age 65.²⁷ States could use Medicaid to cover these so-called “childless adults,” but they had to obtain a Medicaid 1115 waiver to do so. The Medicaid 1115 waiver made coverage more financially risky for states because HHS has required waivers to be cost neutral to the federal government which shifts the risk for cost overruns onto the state while protecting the federal budget.²⁸ While eight states used 1115 waivers to cover childless adults in their Medicaid programs prior to the passage of the ACA, most states were unwilling to take this financial risk.²⁹

Second, federal Medicaid law gave states the same discretion in setting income eligibility limits for adults who qualify as parents as they had in

25. See WALTER I. TRATTNER, *FROM POOR LAW TO WELFARE STATE: A HISTORY OF SOCIAL WELFARE IN AMERICA* 309-10 (6th ed. 1998).

26. See 42 U.S.C. § 1396d(n) (2006).

27. For a more detailed discussion of these rules for adult eligibility, see Sidney D. Watson, *The View from the Bottom: Consumer-Directed Medicaid and Cost-Shifting to Patients*, 51 ST. LOUIS U. L.J. 403, 409 (2007). See also JANE PERKINS ET AL., *THE NATIONAL HEALTH LAW PROGRAM, THE ADVOCATE’S GUIDE TO THE MEDICAID PROGRAM* 3.3-3.10 (2011); KAISER FAMILY FOUND., *THE MEDICAID RESOURCE BOOK* (2003), available at <http://www.kff.org/medicaid/2236index.cfm?RenderForPrint=1>.

28. See 42 U.S.C. § 1315(a)(1) (2006); see also KAISER COMM’N ON MEDICAID & THE UNINSURED, *AN OVERVIEW OF RECENT SECTION 1115 MEDICAID DEMONSTRATION WAIVER ACTIVITY* 4 (May 2012), available at <http://www.kff.org/medicaid/upload/8318.pdf>.

29. See KAISER FAMILY FOUND., *5 KEY QUESTIONS AND ANSWERS ABOUT MEDICAID*, *supra* note 15, at 5 fig.8. Eight states used 1115 waivers to provide full Medicaid coverage to childless adults; additional states used waivers or state funds to provide more limited benefits. *Id.*

setting cash welfare eligibility.³⁰ Federal law specifies that states must cover pregnant women and young children age 1-5 with incomes up to 133% of the federal poverty line,³¹ children age 6-18 living in families with incomes up to 100% FPL,³² and people with permanent and total disabilities and the elderly who receive Supplemental Security Income (SSI),³³ a program for which income eligibility equates to about 75% FPL. However, federal law only requires that state Medicaid programs cover parents with incomes that would have qualified them for the states' old welfare program, Aid to Families with Dependent Children (AFDC), which was repealed as part of President Clinton's welfare reform of 1996.³⁴

While some states expanded income eligibility for parents far above old AFDC limits, just prior to passage of the ACA, seventeen states set income limits for parents below 50% of the federal poverty level.³⁵ In Arkansas, a family of three could earn no more than \$3,180 per year, 17% of poverty. In Alabama, the cut off was \$4,490, 24% of the poverty line. Missouri and Indiana set their limits at 25% of poverty, or \$4,677 for a year.³⁶ In many states, parents working even a few hours a week at minimum wage earn too much to qualify for Medicaid. Nationwide, on average, a parent earning 39% of poverty earns too much to qualify for Medicaid.³⁷

Third, Medicaid programs retain broad flexibility to impose asset tests and require people to exhaust their savings to qualify for Medicaid.³⁸ While nearly every state Medicaid program has eliminated asset tests for children, about half still impose a resource limit on parents. This resource limit

30. 42 C.F.R. § 435.601 (2011); PERKINS, *supra* note 27, at 3.10.

31. 42 C.F.R. § 435.118 (2012); PERKINS, *supra* note 27, at 3.4.

32. 42 C.F.R. § 435.118 (2012); PERKINS, *supra* note 27, at 3.4.

33. 42 C.F.R. § 435.120 (2011). States have the option of either extending Medicaid to all those who qualify for SSI payments, or to those who would have qualified for the state's old Aid to the Permanently and Totally Disabled, the predecessor to SSI. States who opt to limit eligibility to those who would have qualified for APTD, known as 209(b) states, must also provide eligibility for those who meet the disability requirements and spend down their income on medical care to APTD levels. PERKINS, *supra* note 27, at 3.19.

34. 42 C.F.R. § 435.119 (2011); PERKINS, *supra* note 27, at 3.3.

35. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 5, at 11, 42 tbl.6.

36. Annual Update of the HHS Poverty Guidelines, 74 Fed. Reg. 4199, 4200 (Jan. 23, 2009) (noting that the federal poverty level for a family of three was \$18,310).

37. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 4, at 4 fig.6. The figure reported in the charge for working parents takes into account time-limited income disregards that are not available to all working parents. *Id.*

38. See KAISER FAMILY FOUND., THE MEDICAID RESOURCE BOOK 5-6 (2003). For pregnant women and children to be eligible because of poverty, states have the option to impose an asset limit. *Id.* at 6. For adults and children who qualify based upon disability, state asset limits may be no more restrictive than those imposed by SSI, \$2,000 for an individual and \$3,000 for a couple. *Id.* at 6-7. For those qualifying based upon parental status, state rules may be no more restrictive than \$1,000. *Id.*

typically restricts savings and ownership of land, vehicles, and other things that can be liquidated to about \$1,000.³⁹ Almost every state imposes an asset limit in determining eligibility for people with disabilities and the elderly, typically in the range of \$2,000 for an individual and \$3,000 for a couple.⁴⁰

Fourth, many who could qualify for Medicaid coverage are not enrolled because of complicated and cumbersome application and renewal processes. Applying for Medicaid can require filling out a long application form, a visit to a welfare office, and submission of detailed financial and other records. Different categories of eligibility use different methods for counting income and assets that make determining eligibility even more complex and time consuming.⁴¹ The upshot of all this administrative complexity is that nationwide Medicaid enrolls only about 57% of those who are eligible for coverage.⁴²

Medicaid's welfare roots and rules have created a safety net health insurance program for adults defined by unfair and inequitable exclusions: Low wage working parents, like Sandra and Manuel Pico, make too much to qualify. Hardworking men and women like Mathew Solis cannot qualify no matter how poor they are because they are not caring for children. People with chronic conditions and disabilities must choose between trying to work or going on SSI to qualify for Medicaid. In a world in which low wage work typically does not offer health insurance benefits, Medicaid's old division between the "worthy poor" and the "unworthy poor," which disqualifies those who work, seems ill-conceived and counterproductive. People who can qualify for Medicaid or have a family member or friend who rely on Medicaid have a good opinion of the program.⁴³ However, Medicaid's exclusion of working low-income adults has long made the program politically unstable and subject to distrust and resentments.⁴⁴

The ACA dramatically changes Medicaid from a welfare program to a social insurance model. Rather than seeking to exclude people based upon categories of eligibility or old notions of worthiness and unworthiness, the ACA uses Medicaid as the foundational block in a multi-layered system that offers access to affordable health insurance to all Americans and documented immigrants. In removing Medicaid's welfare rules and making

39. *Id.* at 6-7; KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 4, at 8.

40. *Id.*

41. See KAISER FAMILY FOUND., *supra* note 38, at 6-8.

42. See MANATT HEALTH SOLUTIONS ET AL., MEDICAID EXPANSION: FRAMING AND PLANNING A FINANCIAL IMPACT ANALYSIS 4 (2012).

43. KAISER FAMILY FOUNDATION, KAISER HEALTH TRACKING POLL (2011), available at <http://www.kff.org/kaiserpolls/upload/8190-F.pdf>.

44. See Ed Sparer, *Gordian Knots: The Situation of Health Care Advocacy for the Poor Today*, 15 CLEARINGHOUSE REV. 1, 3-7 (1981).

Medicaid part of a multi-tier insurance system for all, the ACA does transform Medicaid.

III. NEW MEDICAID – A DESCRIPTION

Effective January 1, 2014, the ACA reconfigures Medicaid from a welfare safety net with holes into part of a new social health insurance system that guarantees all non-elderly Americans and legal immigrants access to affordable health insurance. Those who have affordable and high quality employer-sponsored insurance keep what they have. Others have new options for coverage. After *NFIB*, the ACA allows, but does not require, state Medicaid programs to cover all citizens and certain immigrants with incomes up to 133% of the federal poverty line.⁴⁵ For those earning between 100 and 400% of the FPL, the ACA creates new federal tax credits to subsidize sliding scale premiums for individual health insurance.⁴⁶ The ACA also authorizes Health Insurance Exchanges (Exchange(s)), new marketplaces to improve competition, affordability, and choice in the individual and small group health insurance, and the portal through which individuals and families will apply for Medicaid and premium tax credits.⁴⁷

In creating this new system of affordable insurance for all, the ACA does not change the fundamental structure of the Medicaid statute; it does not do away with categories of eligibility or state discretion to cover optional groups

45. See ACA §§ 2001(a)(1), 2101 (codified at 42 U.S.C. §§ 1396a, 1397ee(b) (2011)). Only American citizens and specific categories of lawfully residing immigrants can qualify for Medicaid. 42 C.F.R. § 435.406(a)(1) (2011). The Personal Responsibility and Work Opportunity Reconciliation Act, enacted in 1996, barred most lawfully residing immigrants for Medicaid during their first five years in the U.S., except for emergency treatment. Pub. L. No. 104-193 § 403, 110 Stat. 2265 (codified at 8 U.S.C. § 1613 (2011)). More recently, Congress gave states the option to receive federal Medicaid matching funds for lawfully residing immigrant children, pregnant women, or both without the five year wait. Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3 § 214(a), 123 Stat. 56-57 (codified at 42 U.S.C. 1396a). Eighteen states have opted to cover immigrant children or pregnant women or both. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 5, at 8. The ACA does not change these rules. Since 2006, states must require that first-time applications for Medicaid document their citizenship by submitting a passport or combination of a birth certificate and identity document, although elderly individuals, people with disabilities, and newborns whose births are paid for by Medicaid are exempt from these requirements. *Id.* at 9. Since January 2010, states have been able to satisfy the citizenship documentation requirement by data matching through the Social Security Administration's database. *Id.* Almost half the states now use or are testing this data-match option. *Id.*

46. ACA § 2001(a)(1) (codified at 42 U.S.C. § 1396a (2011)). Legal immigrants barred from Medicaid during their first five years in the U.S. earning under 100% FPL are also eligible for these premium tax credits. *Id.* § 1401 (codified at 26 U.S.C. 36 (2011)).

47. ACA § 1311 (codified at 42 U.S.C. § 18031 (2011)).

of people in addition to those that states must cover.⁴⁸ It operates within Medicaid's historic statutory structure creating new categories of mandatory eligibility and specifying new mandatory rules for computing income and assets to create a seamless web between Medicaid eligibility and eligibility for the new federal premium tax credits that make private insurance purchased through Exchanges more affordable.⁴⁹ The ACA Medicaid Expansion for adults challenged in *NFIB* is one, although possibly not the most important, piece of this transition in Medicaid.

Section 2001(a) of the ACA, the Medicaid Expansion challenged in *NFIB*, creates a new category of mandatory Medicaid eligibility for adults that includes adults with incomes up to 133% FPL who are not covered by another mandatory category of eligibility.⁵⁰ Section 2001(a) creates a new Medicaid category for non-elderly adults who are *not* pregnant women, parents, permanently and totally disabled and unable to "engage in substantial gainful employment," or Medicare-eligible.⁵¹

The new ACA Medicaid Expansion category is targeted at childless, non-disabled adults. It also allows parents and adults with disabilities who have incomes above mandatory income cut-offs to qualify for Medicaid, which assures that all non-elderly adults with incomes up to 133% of the FPL fall within a Medicaid mandatory category of eligibility.⁵² Thus, parents with incomes below the old AFDC cut-off will be covered in the pre-ACA parent category while parents with higher incomes will be covered in the new ACA Medicaid Expansion category. Adults with serious disabilities who do not work and have incomes below 75% FPL will still be covered in the category for the disabled, but adults who are disabled and working with earnings up to 133% FPL will qualify through the ACA Expansion.

48. *Id.* § 2001(a) (codified at 42 U.S.C. § 1396a (2011)).

49. See *id.* § 2001 (amending 42 U.S.C. § 1396a to add another mandatory category of Medicaid eligibility for adults); see also *id.* § 2002 (codified at 42 U.S.C. § 1396a (2011)) (proving that income eligibility for most non-elderly will be determined using modified gross income rather than income counting methodologies and that no asset test may be imposed). The Patient Protection and Affordable Care Act also gives states a number of new options for using Medicaid to expand Medicaid services, particularly long term care services and supports. *Id.* § 2001 (codified at 42 U.S.C. § 1396 (2011)).

50. ACA § 2001(a)(1) (codified at 42 U.S.C. § 1396a (2011)) ("[B]eginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income . . . does not exceed 133 percent of the poverty line . . . applicable to a family of the size involved . . .").

51. ACA § 2001(a) (codified at 42 U.S.C. § 1396a (2011)).

52. Medicaid Program Eligibility; Eligibility Changes Under the Affordable Care Act of 2010, 57 Fed. Reg. 17144, 17157 (March 23, 2012) (to be codified at 42 C.F.R. pts. 431, 435, 457) (explaining how this new category will work with existing categories of coverage for adults).

Other ACA amendments to Medicaid also play a crucial role in transforming Medicaid into a solid, seamless base for a comprehensive national plan to make health insurance available to all children and working age adults. None of these other provisions were challenged in *NFIB*. All remain in effect and place mandatory requirements on states that become effective January 1, 2014.⁵³

First, the ACA also expands an existing mandatory category of eligibility for children to guarantee that all children with incomes up to 133% FPL qualify for Medicaid.⁵⁴ The Medicaid statute already included a mandatory category of eligibility requiring states to cover all pregnant women and children ages 1-5 with incomes up to 133% of the FPL.⁵⁵ The ACA amended the Medicaid category that covers children ages 6-18 increasing the income limit from 100% FPL to 133% FPL for older children. This Medicaid expansion for children has been less contentious because all states already cover children up to this income level either through optional Medicaid coverage or through a separate Children's Health Insurance Program (CHIP).⁵⁶ The ACA phases out coverage through CHIP, moving children into the same Medicaid health insurance coverage as their parents.⁵⁷

The ACA also changes how states compute income for purposes of determining Medicaid income eligibility. For most non-elderly adults and children, states must calculate income eligibility using modified adjusted gross income, a figure drawn from the Internal Revenue Code, used for income tax purposes, and reported on line 37 of one's annual income tax return.⁵⁸ The ACA streamlines the income eligibility process replacing numerous category-specific income exclusions with one 5% income disregard, essentially increasing the income limit for non-elderly adults and

53. *NFIB*, 132 S.Ct. at 2608.

54. ACA § 2001(a) (codified at 42 U.S.C. § 1396a (2011)).

55. See 42 U.S.C. § 1396a(a)(10)(A)(i)(III) (2011); PERKINS, *supra* note 27, at 3.3.

56. Medicaid Program Eligibility; Eligibility Changes Under the Affordable Care Act of 2010, *supra* note 52, at 17214-215. For children's eligibility, see KAISER FAMILY FOUND., *Income Eligibility Limits for Children's Regular Medicaid and Children's CHIP-funded Medicaid Expansions as a Percent of Federal Poverty Level (FPL), January 2013*, STATE HEALTH FACTS (Jan. 1, 2013), <http://www.statehealthfacts.org/comparereport.jsp?rep=76&cat=4>.

57. ACA § 2201 (a)(5) (codified at 42 U.S.C. § 1396w-3 (2011)). The ACA also provides mandatory Medicaid coverage of children aging out of foster care providing coverage until age 26. ACA § 2004 (codified at 42 U.S.C. § 1396e-1 (2011)).

58. See *id.* §§ 2002(A), (G) (codified at 42 U.S.C. § 1396a(e) (2011)); see also Medicaid Program Eligibility; Eligibility Changes Under the Affordable Care Act of 2010, *supra* note 52. The only exception is for those who qualify based upon Medicare eligibility or disability: their incomes will still be computed using standards drawn from disability cash benefit program Supplemental Security Income or specific to the Medicare-related category of eligibility. See ACA § 2002(D) (codified at 42 U.S.C. § 1396a(e) (2011)); Medicaid Program Eligibility; Eligibility Changes Under the Affordable Care Act of 2010, *supra* note 52.

children from 133% FPL to 138% FPL.⁵⁹ This same income methodology will be used for calculating eligibility for the new federal premium tax credits,⁶⁰ thus guaranteeing no gap in coverage between Medicaid and subsidized private insurance.

Just as importantly, for most categories of eligibility for children and non-elderly adults, states may no longer impose an asset limit.⁶¹ Removing the asset requirements not only allows people to qualify for Medicaid without completely exhausting their savings, but also reduces the need for intrusive and cumbersome verification of bank accounts, autos, burial policies, and other items that might be able to be liquidated.⁶² Moving to a standardized income and no asset rules allows for streamlined eligibility determinations and simplified enrollment.⁶³

The ACA also provides that states must use a “no wrong door” approach to streamline and coordinate their Medicaid and Exchange enrollment systems.⁶⁴ Individuals and families will be able to apply for both the new federal income tax credits and Medicaid via the new Exchanges. One application can be submitted online, by phone, or mail. The same financial and other information will be used to determine eligibility for both Medicaid and private insurance subsidies. Secure data exchanges will be able to verify employment, income, social security numbers, and other information with no time delays and without individuals having to locate financial and other records.

Justice Roberts was incorrect when he credited the Medicaid Expansion for adults with transforming Old Medicaid into New Medicaid; a host of ACA provisions transform Medicaid by expanding eligibility, creating uniform and easily understood income limits, dropping asset tests, streamlining the application process, and assuring that individuals and families do not fall off a cliff into no health insurance when their income

59. ACA § 2002(a) (codified at 42 U.S.C. § 1396a(e)(14) (2011)).

60. *Id.* § 1401 (codified at I.R.C. § 36B (2011)).

61. See *id.* § 2002(C) (codified at 42 U.S.C. § 1396a(e) (2011)); see also Medicaid Program Eligibility; Eligibility Changes Under the Affordable Care Act of 2010, *supra* note 52, at 17156.

62. See LEE SUMMER & LEE THOMPSON, THE COMMONWEALTH FUND, HOW ASSET TESTS BLOCK LOW-INCOME MEDICARE BENEFICIARIES FROM NEEDED BENEFITS 6 (2004), available at <http://www.commonwealthfund.org/Publications/Issue-Briefs/2004/May/How-Asset-Tests-Block-Low-Income-Medicare-Beneficiaries-from-Needed-Benefits.aspx>.

63. See, e.g., Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, 76 Fed. Reg. 65909 (Oct. 24, 2011) (explaining that a goal of the administration is to reduce burdensome and unnecessary procedures).

64. ACA § 2201 (codified at 42 U.S.C. § 1396w-3(b)(1)(D) (2011)); KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM, EXPLAINING HEALTH REFORM: BUILDING ENROLLMENT SYSTEMS THAT MEET THE EXPECTATIONS OF THE AFFORDABLE CARE ACT 1 (2010).

increases. These ACA amendments reconfigure Medicaid from a welfare program into part of a larger social health insurance scheme where people can move back and forth between Medicaid, premium tax credits, and employer-sponsored health insurance as their circumstances, income, and employment change. Medicaid is no longer tied to old cash welfare rules that limit who can qualify, force people to exhaust their savings, and require a trip to the welfare office. Old Medicaid was a safety net for less than half of those living at or near the poverty line. New Medicaid will be available to all Americans and many legal immigrants whenever their income dips near the poverty level, part of the ACA's multi-layer social insurance system for providing health insurance for all.

IV. EMBRACING NEW MEDICAID – THE PEOPLE AND FACES OF NEW MEDICAID

Justice Roberts also said that the ACA expansion transforms Medicaid because "[i]t is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health coverage."⁶⁵ While this comment drew an irate response from Justice Ginsburg who noted that living at or below the federal poverty line certainly seemed to denote need,⁶⁶ Justice Roberts' sentiment captures the sea change that the host of ACA reforms brings to Medicaid. Welfare programs, with their old categories of the "worthy poor," complicated asset rules, and intrusive processes, sought to single out those whom society thought the "neediest" and most deserving of special help and compassion.⁶⁷ But these categories and rules also carry a load of historic baggage about "those" people who need help from "us."

The ACA brings "us" into Medicaid and that is why the public, and ultimately state lawmakers, will embrace New Medicaid. Old Medicaid was available only to about one in five low-income adults; the ACA's new social insurance structure opens New Medicaid to all Americans and certain legal immigrants earning at or near the poverty line. Many, maybe most, Americans will use New Medicaid at some point in their lives — it is the new safety net insurer for students, young workers, entrepreneurs starting a new business, those laid off during an economic downturn, and low wage workers working hard in a whole host of jobs that do not offer health insurance, including retail, construction, and service jobs.⁶⁸ Because the

65. *NFIB*, 132 S. Ct. at 2606.

66. *Id.* at 2636 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) ("Single adults earning no more than \$14,856 per year – 133% of the current federal poverty level – surely rank among the nation's poor.").

67. TRATTNER, *supra* note 25, at 54, 254, 285.

68. See KAISER FAMILY FOUND., CHARACTERISTICS OF UNINSURED LOW-INCOME ADULTS 3 (2012). Approximately 78% of the uninsured newly eligible for Medicaid are workers and their

ACA transforms Medicaid into a safety net for all, it transforms Medicaid from being a politically vulnerable welfare program for a few into a politically popular and politically stable social health insurance program along the model of Medicare.

While our historic vision of Old Medicaid as a welfare program may cause us to think of those newly eligible for Medicaid as “poor people” and “the poor,” it would be sloppy policy and bad politics to use these labels to define “New Medicaid.” While some of those eligible for the New Medicaid are the nation’s most needy — those who are homeless, have chronic mental illness, or substance abuse problems — most are middle class Americans entering the workforce for the first time or caught in a temporary financial down turn.⁶⁹

families. *Id.* at 2. They tend to work in agriculture, construction, wholesale and retail, and service jobs in arts, entertainment, and recreation that tend to be low wage and part-time. *Id.* at 3. Slightly more than half (52%) are in families working part time and about a quarter are in families with a full time worker. *Id.* The income limits for the Medicaid Expansion remain low enough that for individuals and a family of two the income from one adult working full time at minimum wage puts them above the income limit of 133% of federal poverty level, \$5,400 for an individual and \$7,200 for a family of two. See *id.* at 2. They primarily work for smaller employers who are less likely to offer health insurance. KAISER FAMILY FOUND., *supra*, at 3. They are also more likely to live in rural America, reflecting the lower wages and higher poverty in small town America. KEITH J. MUELLER ET AL., RUPRI RURAL HEALTH PANEL, MEDICAID AND ITS IMPORTANCE TO RURAL HEALTH 2 (2005), available at <http://www.rupri.org/Forms/IssueBrief.pdf>. While the ACA Medicaid expansion helps adults across the age spectrum, it is particularly important for young adults under 25, more than a quarter of whom will qualify for the Medicaid Expansion. KAISER FAMILY FOUND., *supra*, at 2; see also GENEVIEVE M. KENNEY ET AL., URBAN INST., OPTING IN TO THE MEDICAID EXPANSION UNDER THE ACA: WHO ARE THE UNINSURED ADULTS WHO COULD GAIN HEALTH INSURANCE COVERAGE? 2 (2012). These young adults include high school graduates starting out in low wage jobs, students working part-time, and new college graduates trying to get started in a sluggish economy. KAISER FAMILY FOUND., *supra*, at 6 n.9. More than half those newly eligible are under 35 years of age, 34.5% are between 35-54 years of age, and 13.4% are the near elderly between 55-64. *Id.* at 8 tbl.1.

69. See KAISER FAMILY FOUND., *supra* note 68, at 3. Approximately 78% of the uninsured newly eligible for Medicaid are workers and their families. *Id.* at 2. Almost all the nation’s 630,000 homeless will be newly eligible. See KAISER FAMILY FOUND., MEDICAID COVERAGE AND CARE FOR THE HOMELESS POPULATION: KEY LESSONS TO CONSIDER FOR THE 2014 MEDICAID EXPANSION 1 (2012). Nearly half the nation’s uninsured veterans – 650,000 men and women – will qualify for the Medicaid expansion. JENNIFER HALEY & GENEVIEVE M. KENNEY, URBAN INST., UNINSURED VETERANS AND FAMILY MEMBERS: WHO ARE THEY AND WHERE DO THEY LIVE? 3 (2012); see HYUNGSUNG OH, USC SCH. OF SOCIAL WORK, HEALTHCARE FOR VETERANS IN THE ERA OF PATIENT PROTECTION AND THE AFFORDABLE CARE ACT OF 2010, at 2 (2012). The Expansion will create a new source of health insurance for those with untreated mental illnesses and substance abuse who without outpatient treatment become repeat users of emergency rooms, inpatient psychiatric services, jails, and prisons. See ALLISON HAMBLIN ET AL., CTR. FOR HEALTH CARE STRATEGIES, MEDICAID AND CRIMINAL JUSTICE: THE NEED FOR CROSS SYSTEM COLLABORATION POST HEALTH CARE REFORM 1 (2011); see also MAUREEN McDONNELL ET AL.,

Just because a person earns at or near the federal poverty line is no reason to assign him or her to poverty or low-class status. In America, income does not directly correlate with class. Most Americans, even those at the bottom of the income scale, consider themselves middle class.⁷⁰ Americans judge themselves and others by many variables including education, lifestyle, beliefs, feelings, cultural factors and occupation along with income and wealth.⁷¹ A college degree, family background, and good manners generally count for more in one's twenties than being employed part time as a waiter or barista, or even being unemployed.⁷² Even as we grow older, income does not define our social status or social class as much as how we live our lives.

Most adults newly eligible for Medicaid are middle-class Americans, at the beginning of their working lives or caught in a temporary financial downturn.⁷³ They are Sandra and Manuel Pico, living off one income until Mr. Pico finds work again as a carpenter.⁷⁴ They are Mathew Solis working part-time while he goes to college to get a degree to be a school counselor.⁷⁵

In America, particularly during the most recent economic downturn, income is volatile and there is substantial movement over, under, and around the federal poverty line. Half of all poverty-income spells in the U.S.

CTR. FOR HEALTH & JUSTICE, REALIZING THE POTENTIAL OF NATIONAL HEALTH CARE REFORM TO REDUCE CRIMINAL JUSTICE EXPENDITURES AND RECIDIVISM AMONG JAIL POPULATIONS, ISSUE PAPER 1 (2011); Sidney D. Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357, 370 n.60 (2001) (stating that few of those with substance abuse and mental illness are now eligible for Medicaid).

70. TERESA SULLIVAN ET AL., THE FRAGILE MIDDLE CLASS: AMERICANS IN DEBT 28 (2000) (citing Robert W. Hodge & Donald J. Treiman, *Class Identification in the United States*, 73 AM. J. SOCIOLOGY 535, 547 (1968)). When asked in an open-ended question to identify their class membership, nearly three-quarters of the adult population of the United States volunteer an identification with the "middle" or average" class. *Id.* When given four options for social class (lower, working, middle, upper), roughly 96% of the population places itself in either the working class or the middle class. *Id.* at 301 n.3 (citing Nancy J. Davis & Robert V. Robinson, *Do Wives Matter? Class Identities of Wives and Husbands in the United States 1974-1994*, 76 SOCIAL FORCES 1063, 1068 (1998)). This pattern is evidenced in data from the National Opinion Research Center's annual General Social Survey from 1974 through the 1990s. *Id.*

71. SULLIVAN, *supra* note 70, at 28 (citing MARY R. JACKMAN & ROBERT W. JACKMAN, CLASS AWARENESS IN THE UNITED STATES 216-17 (1983)).

72. *Id.* at 30 (demonstrating that a church minister does not lose middle class status just because her congregation pays a low salary).

73. Most Americans, even those at the bottom of the income scale, consider themselves middle class. See SULLIVAN, *supra* note 70.

74. Johnson & Kennedy, *supra* note 1.

75. *Id.*

last less than four months and only 13% last more than two years.⁷⁶ In a one-year period, 21% of those who began the year earning below the poverty line, moved above the line by the end of the year,⁷⁷ and 3% of those who began the year with higher earnings saw earnings drop below the poverty line by the end of the year.⁷⁸ One study that examined adults with incomes up to twice the poverty level found that during a one year period fully half had income changes that moved them across the 133% of federal poverty line that demarks eligibility for New Medicaid, and 24% moved across the line twice during the year.⁷⁹

The ACA creates a social health insurance scheme that offers access to affordable health insurance as people's job situations change and their income fluctuates. Those with generous employer sponsored and subsidized insurance use that route. Americans at the highest income levels can purchase competitive plans through the Exchange. Moderate-income Americans get new federal premium tax credits. And, the lowest-income Americans have Medicaid. People will move among these various sources of insurance as their life circumstances and jobs change. No one is left out and those who participate in the system contribute based upon their present means and circumstances.

V. CONCLUSION

New Medicaid plays a crucial role in the ACA's new social health insurance for all system. New Medicaid was originally estimated to cover about half of those who will be newly insured — about 16 out of 32 million.⁸⁰ However, the Supreme Court's decision in *NFIB* making the Medicaid Expansion for adults voluntary for states means that Medicaid may not be there for all adults in all states. If states do not expand Medicaid, as many as 17.8 million adults who could be eligible for the Medicaid expansion will be left uninsured, and with no other access to affordable health insurance.⁸¹

76. SULLIVAN ET AL., *supra* note 70, at 63 (citing Press Release, Bureau of the Census, Forty-Six Million Were Poor for Two More Months in 1990, a New Census Report Says (Feb. 3, 1995)). This data is based on the Survey of Income and Program Participation, a longitudinal study of a cross-section of American families. *Id.* at 310 n.102.

77. *Id.*

78. *Id.*

79. Sara Rosenbaum & Benjamin Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 127, 145 (2011).

80. Letter from the Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives (Mar. 18, 2010), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr4872_0.pdf. Figures are for 2019.

81. GENEVIEVE M. KENNEY ET AL., URBAN INST., MAKING THE MEDICAID EXPANSION AN ACA OPTION: HOW MANY LOW-INCOME AMERICANS COULD REMAIN UNINSURED 1 (2012). Under the

Voluntarily expanding Medicaid and assuring that everyone has access to affordable health insurance makes sense for states. New Medicaid makes sense as a matter of public health, healthcare delivery and state finances. Most importantly, though, New Medicaid makes political sense: It creates a safety net for all and is likely to become one of the Nation's most popular social insurance programs.

Expanding Medicaid saves lives. A recent study comparing three states that had expanded Medicaid coverage to childless adults with three states that had not found that death rates were 6% higher in states with no Medicaid coverage.⁸² A recent randomized controlled study, the gold standard of clinical research, provides strong evidence of the stark difference that Medicaid makes in access to care and health status. The study followed adults with and without Medicaid in Oregon and concluded that adults enrolled in Medicaid had improved health status, less anxiety and depression, and fewer financial problems related to medical care.⁸³

Medicaid is a program that has proved its worth. It costs one-third less per person than private insurance.⁸⁴ It offers comparable access to care and quality outcomes as private insurance.⁸⁵ It also allows states to create

ACA's multi-layered social insurance system, for those with incomes below 100% of FPL cannot qualify for premium tax credits offered through the Health Insurance Exchange, Medicaid is their only option. In states that do not expand Medicaid, those with incomes between 100-133% of FPL are eligible for sliding scale premiums equal to 2% of their income to purchase Exchange offered insurance plans, but these premiums, which are higher than Medicaid premiums, may effectively price these adults out of health insurance and leave them uninsured. See ACA § 2001(a)(1)(C) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2011)) (expanding Medicaid for adults up to 133% FPL); *id.* § 1401(a) (codified at I.R.C. § 36B(b)(3)(A)(ii) (2011)) (federal premium tax credits available to those with incomes between 100-138% FPL); *id.* § 1401(a) (codified at I.R.C. § 36B(c)(2)(B)(i) (2011)) (providing that federal premium tax credits are not available to those eligible for Medicaid).

82. Benjamin Sommers et al., *Mortality and Access to Care among Adults after State Medicaid Expansions*, 36 NEW ENG. J. MED., 1025, 1025 (2012) (finding a 6% drop in overall death rate for adults in states with expanded Medicaid coverage compared to states that did not expand coverage).

83. Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, 3-4, 26-29 (Nat'l Bureau of Econ. Research, Working Paper No. 17190, 2011), available at www.nber.org/papers/w17190.

84. See CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 4 (July 2012) (estimating that in 2022 the cost of private insurance through the Health Insurance Exchanges will be \$9,000 per year and Medicaid costs will be \$6,000 per year); see also Brietta R. Clark, *Medicaid Access, Rate Setting and Payment Suits: How the Obama Administration Is Undermining Its Own Health Reform Goals*, 55 HOW. L.J. 771, 788 (2012) (estimating that Medicaid costs 20% less than private insurance).

85. See KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE MEDICAID PROGRAM AT A GLANCE 2 (2012).

special programs to meet the needs of special populations, and gives states the flexibility to target provider reimbursement to support safety net providers and underserved communities assuring that state-level delivery system needs get addressed.⁸⁶

Expanding Medicaid also makes sense in terms of state expenditures. The Medicaid Expansion costs states very little in additional state Medicaid spending, on average only about 2.8% more over ten years than they would spend on their old, much smaller Medicaid programs.⁸⁷ Moreover, a growing number of states are concluding that the Medicaid Expansion for adults will actually save states money by reducing the need for other state spending for medical, public health, and social services for uninsured adults.⁸⁸ The ACA provides a very generous federal match to cover the costs

86. See ANDY SCHNEIDER ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED: THE MEDICAID RESOURCE BOOK 85-86, 91, 111 (2002).

87. The CBO estimates that the additional costs to the states for the Medicaid Expansion for the first nine years, from 2014-2022, to be only 2.8% more than they would spend on their old, less generous Medicaid programs. See CONG. BUDGET OFFICE, UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT 6 n.14 (2012). See also Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, House of Representatives, tbl.4 (March 20, 2010); JOHN HOLOHAN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS 1 (2012). These cost estimates include both the costs of ACA's Medicaid Expansion for adults as well as increased coverage of children and adults who are presently eligible but not enrolled. Millions of low-income American are currently eligible for Medicaid but not enrolled because of enrollment barriers and lack of information. States have been worried that the ACA will create a "welcome mat" effect resulting in these uninsured individuals coming "out of the woodwork" and signing up for Medicaid thanks to heavy media coverage, new streamlined enrollments produces required by ACA and the individual mandate to obtain coverage. In some states, 5 to 8% of the entire population under age 65 are uninsured but Medicaid-eligible and the welcome mat effect could draw out as many as 9 million uninsured children and adults. This welcome mat effect is calculated into the costs estimates and will occur whether or not states embrace the ACA. For a discussion of these issues, see Benjamin D. Sommers & Sarah Rosenbaum, *Medicaid Expansion—The Soft Underbelly of Health Care Reform?*, 363 NEW ENG. J. MED. 2085, 2085-86. (2010); Benjamin D. Sommers & Arnold M. Epstein, *Why States are So Miffed about Medicaid—Economics, Politics, and the "Woodwork Effect,"* 365 NEW ENG. J. MED. 100, 101 (2011).

88. See, e.g., *Medicaid Expansion Arkansas: Decision Pushed to 2014*, MEDICAID EXPANSION (Dec. 28, 2012), <http://medicaidexpansion.com/arkansas-medicaid-expansion/>; January Angeles, *Arkansas Shows Why Medicaid Expansion is a Good Deal for States*, OFF THE CHARTS (July 20, 2012, 3:30 PM), <http://www.offthechartsblog.org/arkansas-shows-why-medicaid-expansion-is-a-good-deal-for-states/> (examining the benefits of Medicaid expansion for Arkansas); Jason Rosenbaum, *Nixon Makes Strong Push for Medicaid Expansion, Faces Stiff Challenge in GOP-Controlled Legislature*, ST. LOUIS BEACON 1 (Nov. 29, 2012), https://www.stlbeacon.org/#/content/28252/nixon_medicaid_expansion_republicans; UNIV. OF MO. SCH. OF MED. DEP'T OF HEALTH MGMT AND INFORMATICS & DOBSON DAVANZO & ASSOC., LLC, *THE ECONOMIC IMPACTS OF MEDICAID EXPANSION ON MISSOURI* vi (2012),

for newly eligible adults with the federal government paying 100% in 2014 through 2016, with a gradual reduction to 90% in 2020 and thereafter.⁸⁹

The finances of the Medicaid Expansion should work for states, but the economic benefits alone will not sell the Medicaid Expansion. Historically, Medicaid has not had the popular support or political stability of Medicare. As a program with its roots in welfare, Medicaid has often seemed complicated, unfair, and stigmatizing. It excludes more low-income adults than it helps, and in many states it excludes the low-wage workers who have no other source of health insurance.

As reconceived by the Affordable Care Act, Medicaid is to be the safety net insurer for everyone not just some. The ACA removes the welfare exclusiveness — and stigma — from Medicaid making it part of a larger social insurance system that assures access to health insurance as income and jobs fluctuate, and as people's financial circumstances change over the lifetimes. By expanding Medicaid to cover everyone with incomes up to 133% FPL, and by offering other coverage to those with higher incomes, the ACA gives Medicaid the dignity and the inclusiveness of a social insurance program.⁹⁰

available at <http://www.mffh.org/mm/files/MUMedicaidExpansionReport.pdf> (examining the benefits of Medicaid expansion for Missouri); Andy Miller, *Medicaid Expansion: Room for Compromise?*, GEORGIA HEALTH NEWS (Aug. 29, 2012), <http://www.georgiahealthnews.com/2012/08/medicaid-expansion-room-compromise/> (predicting Georgia Medicaid expansion); Barry Massy, *Report: NM Gains Initially with Medicaid Expansion*, BLOOMBERG BUSINESS WEEK, (Sept. 28, 2012), <http://www.businessweek.com/ap/2012-09-28/report-nm-gains-initially-with-medicaid-expansion> (examining the benefits of Medicaid expansion for New Mexico). The Urban Institute concludes that net savings from reductions in state funded uncompensated care and mental health services along with Medicaid eligibility transitions from optional categories to the new Medicaid Expansion category will result in net savings to states of \$40.6 to \$131.9 billion over the first six years, 2014-2019. See STAN DORN & MATTHEW BUETTGENS, URBAN INST., NET EFFECTS OF THE AFFORDABLE CARE ACT ON STATE BUDGETS 2 (2010). Shifting Medicaid eligibility from optional categories saves between \$21.3 and \$28.2 billion. Replacing state and local uncompensated care with Medicaid saves \$42.6 to \$85.1 billion. Moving mental health services, to the extent possible, to Medicaid saves \$19.9 and \$39.7 billion. *Id.* at 1; see also MANATT HEALTH SOLUTIONS, STATE HEALTH REFORM ASSISTANCE NETWORK, MEDICAID EXPANSION: FRAMING AND PLANNING A FINANCIAL IMPACT ANALYSIS 6 (2012), available at <http://www.statereform.org/node/10583>.

89. ACA § 2001(a)(3) (codified at 42 U.S.C. § 1396d(y)(1)(A)-(E) (2011)).

90. TRATTNER, *supra* note 25, at 327. "[W]hereas Medicare was given the dignity of Social Security, Medicaid was burdened with the stigma of public assistance." *Id.*

